NEW HAMPSHIRE BOARD OF MEDICINE
121 SOUTH FRUIT STREET, SUITE 301
CONCORD NH 03301-2412
(603) 271-6930
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO WHOM IT MAY CONCERN:

I, _____, do hereby authorize any physician, hospital, institution, other person, firm or corporation to release, disclose or use any protected health information ("PHI") about me upon presentment of this authorization, or any photostatic copy of the same, to the New Hampshire Board of Medicine "(Board") or any member or authorized agent of the Board by certified mail, or in person to any designee of the Board.

This authorization permits any physician, hospital, institution or other person, firm or corporation to release disclose or use the following individually identifiable health information about me, any information, any information, records, x-rays, papers, notes, histories or any other papers concerning any treatment, examinations, stays or periods of hospitalization, confinement, diagnosis, or any other information pertaining to and concerning the physical and/or mental condition of _____. This release/disclosure or use also includes the authority to copy any and all such information, records, papers, notes, and histories, etc.

The above information will be released, disclosed or used by the Board, any member of the Board or any authorized agent of the Board in the investigation and/or prosecution of misconduct by one of its licensees. The purposes have been provided so that I can make an informed decision whether to allow release of the information.

This authorization will expire on _____or, upon the conclusion of the Board's investigation and/or prosecution of misconduct of its licensee whichever comes later.

I, _____ acknowledge that I have a right to refuse to sign this authorization. I further acknowledge that when my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the Board, or the recipient, and may no longer be protected by the federal HIPPA Privacy Rule.

I acknowledge that, by this authorization, I have been referred to the provisions of *45 CFR section 164.520* for a more complete description of uses and disclosure of medical records and information. I have the right to review the provisions of that section.

I understand that I have a right to revoke this authorization except to the extent that the Board has acted in reliance upon this authorization. I understand that any such revocation must be provided in writing. My written revocation must be submitted to the Board at the above stated address.

Dated at _____, _____on the _____day of _____, 2017.
City/Town State

_____
Print Patient's Name and Patient's Date of Birth:

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Signature of Witness Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION UPON REQUEST.